Comparative Psychoanalysis on the Basis of a New Form of Treatment Report: The Case Amalia X[1]

HELMUT THOMÄ AND HORST KÄCHELE

[1] Revised version of a paper given at the 43rd IPA Congress in New Orleans. Some parts were taken from a paper on the same topic that was on the IPA Homepage.

Introduction

Although making comparisons, i.e. judging similarities and differences, is part and parcel of our life and of our professional thinking and acting, the phrase ”comparative psychoanalysis” is new to our vocabulary[2]. To our knowledge, only Scarfone (2002) has recently used it[3]. In German the designation ”vergleichende Kasuistik” (Engl.: comparative case study, Jüttemann 1990) is often used. It refers to a qualitative comparison of various forms of psychotherapy, psychoanalysis among them. In view of the official recognition of psychoanalytic pluralism brought about by the courage of Wallerstein (1988, 1990), we are now obliged to compare various psychoanalytic techniques and theoretical assumptions with each other. To make the comparison reasonable, reliable and fruitful, shared criteria are needed. In membership papers and published case reports, criteria are usually only implied, if not totally missing. Eagle's (1984) complaint is still justified: "It seems to me ironic that psychoanalytic writers attempt to employ clinical data for just about every purpose but the one for which they are most appropriate – an evaluation and understanding of therapeutic change."

A corollary of comparative psychoanalysis is the growing interest in different ways of documenting clinical facts. Within the last decade an impressive number of original papers on this topic have been published. In his foreword to the special 75th anniversary edition of the *International Journal of*

[2] R. Wallerstein has drawn our attention to R. Schafer´s paper on "Wild Analysis" (1985), in which he suggested replacing "wild" by "comparative" psychoanalysis. Schafer compared the systems of Melanie Klein, Heinz Kohut, and Merton Gill. Of course nobody would regard the three theories and their considerable merits as constituting wild psychoanalysis in themselves. Unfortunately the criteria on which Schafer's comparison is based are not specified with regard to their pragmatic truth and their therapeutic qualities.

[3] Scarfone's (2002) commentary in Barros' (2002) paper in the series "The analyst at work" of the *International Journal of Psychoanalysis* was subtitled "An essay in comparative psychoanalytic practice".

Psychoanalysis, devoted to ”Conceptualisation and Communication of Clinical Facts in Psychoanalysis” Tuckett (1994) wrote: ”After 75 years it is time not only to review our methodology for assessing our truth, but also to develop approaches that will make it possible to be open to new ideas while also being able to evaluate their usefulness by reasoned argument. The alternative is the tower of Babel” (p. 865). Therefore to make ”comparative psychoanalysis” a fruitful enterprise, it is essential to evaluate how the treating analyst applies his professional knowledge in specific interactions.

In order to facilitate a critical discussion we divide this paper into two parts. First, we make some statements about our psychoanalytic thinking and then we present an annotated transcript of an analytic case, in order to illustrate how audio-recording can be used as an evidential basis for validation; we do this under the following headings:

PART I Theoretical Points of View

1.1 How Theory Shapes Technique

The relationship between techniques and underlying theories is a very old problem. Eighty years ago Ferenczi and Rank (1924) attempted to clarify ”the relationship between analytic technique and analytic theory” and to investigate ”the extent to which each currently assists or obstructs the other” – Freud`s (1922d, pp. 267-270) prize question. Inspite of Ferenczi`s justified hope, the award was not granted and the book of the two authors was heavily criticised by the young Franz Alexander (1925), who expressed the opinion of the majority, including Freud.[4] Many years later Pulver (1987) aimed at a more rigorous comparison in a survey which dealt, in practice, with the contrast between ‘common ground’ and ‘pluralism’. These issues have come to be known since the Montreal Congress of the IPA and in the light of Wallerstein’s seminal contributions (2002) to the debate.

Under the title: ”How Theory Shapes Technique: Perspectives on a Clinical Study” Pulver (1987) edited a symposium which was based on three sessions of an analyst’s notes (Silverman), his interpretations and the patient’s reactions. This clinical material was examined by ten prominent representatives of various psychoanalytical schools.

As might be expected, Pulver’s comparison demonstrated vast differences in clinical evaluation depending on the analyst's theoretical orientation. Indeed this study serves to undermine the belief that there is indeed a ”common ground” in contemporary clinical psychoanalysis. In view of these differences, the importance of research in clarifying their nature, and their effects on the therapeutic process and outcome cannot be overestimated.

[4] in 1937 Alexander was criticizing Ferenczi because of his emphasis on the emotional experience, but today the ”corrective emotional experience” (without Alexander's role-playing) is recognised in all schools (Marohn 1990).

A.E. Meyer (1994) called this procedure the ”Pulver test”, implying that it functioned as a kind of projective test like the Rorschach or the TAT: all participants receive the same complex body of information allowing for multiple interpretations. As in similar experiments like the ones by Streeck (1986, 1995) or Fosshage (1990), the instruction that the analysts should interpret according to their own particular school naturally maximizes divergences and minimizes possible consensual validation. Especially irritating was the claim - tacitly or explicitly made by these participating analysts - that their own particular interpretive bent is the true one and therefore therapeutically the more successful. We need ”remedial strategies” in the sense of Rubovits-Seitz (1992), to minimize such unqualified assertions. “This general difficulty, that such therapeutic observations and reports are inevitably ‘method-dependent’ or ‘perspective-dependent’, had been argued systematically by the British philosopher Farrell in the 1960’s (and was, of course, elaborated later, without acknowledgement, by US-philosopher Grünbaum; see p. below). In response to Farrell, however, the countervailing possibility of developing “remedial strategies” for ‘decontaminating’ such material was illustrated by Cheshire, by analogy with the tactics used in other empirical disciplines which have ways of dealing with contaminated or distorted observational data (1975, pp. 69-77 & 77-86).

What can be done when experts agree to disagree? There is a wide range of reactions. After many years of dogmatic powergames, psychoanalysts are more tolerant of each other today. The pressure from outside furthers the reconciliation amongst the various psychoanalytic groups. Pulver’s conciliatory reaction to the serious divergences is typical: he concludes that the differences of opinion between the participants are more apparent than real:

”The therapist may be saying essentially the same thing to the patient, but in different words. The patient wants to get used to the therapist’s words, in fact to feel understood. For instance, this patient might feel that her ineffable feeling of

defectiveness was understood by a Kleinian who spoke of her envy, a self-psychologist who spoke of her sense of fragmentation and a structural theorist who spoke of her sense of castration." (Pulver 1987, p. 298)

Thus Pulver assumes that this patient had insights that could have been expressed in different terminology yet that the latter would simply represent metaphoric variations on the same theme. Joseph (1984) argued in a similar vein by referring to unconscious linkages. For example, an interview covering anxiety and loss touches both on unconscious preoedipal separation anxiety and on castration anxiety. Certainly in response to the word "loss," every individual will recall many experiences that may be interrelated although the losses are of different sub-types. Nevertheless, though such reference to overarching metaphors is an attractive idea, we think it is misused here as a means of overcoming legitimate controversies instead of providing scientific clarification of various theories. "For it is still necessary to ask whether such clashes of terminology reflect no more than different ways of talking about the same thing or whether they are implicitly attributing different properties (or underlying causes etc.) to whatever is in question; and, even when it is clearly the latter situation, we are easily tempted to invoke 'overdetermination' to save us from the contentious task of separating sheep from goats. In any case, we shall be reminded of the dispute between Freud and Janet over whether talk about 'the Unconscious' was a reference to a psychological entity of some kind or just a 'figure of speech' (sp. Cheshire 1975, pp. 53-68)

The desire to find a lingua franca in the contemporary psychoanalytic Tower of Babel stimulated a "search for common ground" at the IPA congress in Rome. As president of the IPA, Wallerstein (1990) underestimated, perhaps for diplomatic reasons, the effects of differences (and even contradictions) between various theories and school-related techniques upon the observation of clinical phenomena. His great attempt to forge agreement and unity among the schools,

at least on the clinical level, was unable to bridge or reconcile true antitheses. He sought a common ground in the observational data. But the examples cited from the work of S. and E. Fine (1990, 1991) as well as those from Richards and Richards (1995) support quite a contrary conclusion: observational data are colored from the outset in line with the various theories being used. Such terms as ”transference,” ”countertransference,” ”resistance” and the like have very different meanings in various psychoanalytic schools (Richards 1991). At the congress in Rome, Schafer (1990) seems to have met the Zeitgeist by bluntly stating the psychoanalytic pluralism is “in”. This pluralism exerts a tremendous pressure to undertake comparative therapy research.

There are many psychoanalyses today. We doubt that the ”convergence” has become any greater since the Rome congress (Wallerstein 2002). At any rate, since psychoanalysis is what psychoanalysts do, as Sandler[5] (1982, p. 45) boldly and briefly put it, the practice of individual analysts has to be investigated in order to get as close as possible to primary data. It is but metaphorical to claim that we are all doing the same thing. Commonalities are beautifully expressed and even created by metaphors. To be well-contained, to have an analyst who functions as a “container” and “digests” or “metabolizes” unconscious elements are nothing more than attractive metaphors. "Containment" – the most recent all-embracing and fashionable metaphor – is indeed completely disconnected from Bion’s quite specific theory, and is used merely as a vague ‘figure of speech‘ to designate the supportive and helping function of a therapist. In this sense every successful analyst is a Bionist. This loose metaphorical use of "containment" is

[5] In view of the justifiable criticizms of the training within in the IPA, Sandler’s subsequent qualification that his simple definition applies only to those analysts properly trained under the auspices of the IPA, cannot be upheld today (Balint 1948, Thomä 1993, Thomä and Kächele 1999, Kernberg 2000, Kächele and Thomä 2000, Auchincloss and Michels 2003). Sandler´s qualification is in any case unhelpful, because it is logically circular – for it says, in effect, that you are doing ‘proper analysis’ only if you have been ‘properly trained’; and you are ‘properly trained’ only inasmuch as they trained you to do ‘proper analysis’.

quite different from the Kleinian-Bionian theory of unconscious phantasies and Bion's hypothesis about alpha- and beta-elements. The metaphor does not express true convergences. The same goes for the indiscriminate use of 'projective identification', when analysts do not say whether they are using the term in Klein's original sense or in the significantly different one given to it by Bion.

Among the many reasons for unproductive controversies the following are prominent: 1) The reader of analytic interpretations is at a loss if he/she knows nothing about the cognitive and emotional approach of the treating analyst in general and about how that approach is applied in a concrete situation with a particular patient. 2) Neither of the two participants in the interaction, patient and analyst, are known to the critical reader. As all kinds of ideas tend to come up in a case discussion the "personal equation" is very influential: The recipient puts himself in the shoes of the treating analyst; and this is all the more so, the less he knows about "how the mind of the (particular) analyst works" (Ramzy, 1974). 3) Alternative points of view are then expressed before the ones contained in the original story are discussed in their own right. Too often the deficiencies of "studies on consensus between analysts" are a result of the failure to take the colleague's points of view seriously before thinking about alternatives. The disappointing findings of these consensus investigations have their roots in a design which did not adequately define the frame of reference (Seitz 1966). When we embarked on our own study on various forms of anxiety we gave the investigation a definite frame and arrived at a fairly reliable consensus among analysts (Thomae et al. 1976, cf. Caston 1993, Caston & Martin 1993).

1.2 From Case History to Treatment Report

In order to evaluate therapeutic change, detailed treatment reports have to be made accessible to the professional community. The tradition so far has centred upon the publication of case histories (Kächele 1981). Freud's main

objective was to reconstruct the genesis of psychopathological disturbances; thus the move from writing case histories to writing detailed treatment reports marks a new era in psychoanalytic practice.

The special tension contained in Freud's case histories results from the fact that all descriptions in them have the goal of making the background of the patient's thoughts and actions plausible in order to be able to present explanatory outlines of their history. (cf. Ulm Textbook vol.2 p. 13)

Since the primary purpose of Freud's case histories was to reconstruct psychogenesis, i.e., to demonstrate that symptoms have repressed unconscious causes, the description of therapeutic technique took second place. Freud did not discuss technical rules systematically in his treatment reports. He only mentioned in a rather fragmentary way what he felt, thought, interpreted or otherwise did in a particular session.

Freud distinguished between case histories, which he occasionally referred to as the 'patient histories' (*Krankengeschichten*), and treatment histories. In the Ulm textbook we have adopted this distinction, except that we prefer the designation "treatment reports" because of the significance of the different forms of documentation. Freud pointed out in an early publication the difficulties confronting suitable reporting.

"My object in this case history was to demonstrate the *intimate structure of a neurotic disorder* and the *determination* of its symptoms; and it would have led to nothing but hopeless confusion if I had tried to complete the other tasks at the same time. Before the technical rules, most of which have been arrived at empirically, could be properly laid down, it would be necessary to collect material from the histories of large number of treatments". And he confessed: "Indeed I have not yet succeeded in solving the problem of how to record for publication the history of a *treatment* of long duration" (Freud 1905e, pp. 12-13, pp. 9-10, cf. 1912e, pp. 114, emphasis added).

The criteria that must be applied in order to write a convincing case history, i.e., a reconstruction of the conditions of genesis, are different from those for those that apply to descriptions in a treatment report. Treatment reports focus on determining whether change has occurred and what conditions led to the change. Freud could be satisfied with making relatively rough distinctions that left a lot to subsequent research. From today's point of view, however, Freud's case histories are not suited to serve either as a model for a reconstruction of the aetiology or as a paradigm for records of psychoanalytic treatment. The task of creating the most favorable conditions for change and of investigating the therapeutic process is a very challenging one. Similarly, research that is designed to provide evidence relevant to the etiological hypotheses demands too much of the individual analyst. Following Grünbaum's (1984) criticism, Edelson (1988) drafted an ideal model according to which a case history and a treatment report would have to be written today in order to make it possible for hypotheses to be tested.

It is essential that the treatment report contains at least some of the elements of the "new genre" Spence (1986) is pleading for: "What is needed is a new genre and a new mode of clinical reporting and we are reminded of Eissler's prediction that 'when a case history has been published of a quality superior to the five pillars on which psychoanalysis now rests (Freud's five case reports), then psychoanalysis will have entered a new phase' (Eissler, 1963, p 678). We need to have a clean break with what I call the Sherlock Holmes tradition, and to develop methods of presenting our data which will allow the reader to participate in the argument, allow him to evaluate the proposed links between evidence and conclusion, and which open up the possibility of refutation, disconfirmation, and falsification (none of these moves is now possible). The new genre would also provide us with an archive of specimen interpretations, specimen dreams, and specimen cases which would be accessible to other readers, perhaps even from

other schools of psychoanalysis, and which could be used in a cumulative manner to combine data from many patients and many analysts." (Spence, 1986, p. 14).[6]

The "new genre" implies a different scientific ideal from the one Freud adhered to. The investigation centers upon therapeutic interventions and their effects on changes.

Plagued by the problem of suggestion, Freud aimed at a pure "uncontaminated" method – seemingly in agreement with the philosopher of science and learned physicist Grünbaum. This claim for virginity of data from the clinical situation, however is utopiean. If proof of the causal relationship requires that the data be free of any trace of suggestion, in order to obtain uncontaminated data by means of pure interpretations, then the therapy is ruined.

It is obvious that the analyst influences the patient even if it seems to him he is only directing his interpretations to the unconscious and has no further aims. Not to acknowledge this would be a self-deception, and it would open the door to hidden manipulation. This dilemma is a consequence of Freud's scientific position, which until recently has severely hampered the development of specific forms of research on psychoanalytic process- and outcome. It is ironic that the idea of purity and the search for uncontaminated data destroyed the home ground of psychoanalysis (Stone 1961). Now systematic investigations are examining the question how the psychoanalytic method influences the patient (and vice versa). To objectify the intersubjective process makes it necessary to reflect upon various kinds of suggestion and "contamination". Strenger (1991, p. 106) speaks of Freud's scientific ideal as a purity myth. However, it is obvious that "psychoanalysis is history, but history is never pure... therefore we must eliminate this pure/impure opposition. Things are always impure, because human

[6] In part 2 of our paper we demonstrate the various methodological levels of case studies starting with systematic clinical description (Kächele & Thomä, 2005).

beings are impure. In fact, those who strive to avoid influencing others end up doing so in a way that is even more worrying. Because the will to be pure, the will not to influence, is in itself a mighty source of influence. Those endeavouring to be pure are those who scare me most! This will to purity can lead us back to the origins of psychoanalysis to Freud's desire to do science in this sense of doing physics, in the classical sense of the word. The wish of Freud's, still present today, is a symptom I want to challenge." (Strenger 1991, p. 106).

We arrive at a very surprising conclusion: Freud's and Grünbaum's combined attempts at purification destroy both therapy and appropriate research in psychoanalysis. The difference between the founder of psychoanalysis and one of its sharpest contemporary critics is that Freud believed that the causal nature of psychoanalytic assumptions can be proven in the therapeutic situation itself, whereas Grünbaum rejected this opinion with regard to Freud's Tally-argument (Freud 1916/17, p. 452). Grünbaum's argument is based on the assumption that the therapeutic application of the psychoanalytic method follows the scientific paradigm of classical physics. This mistaken assumption has been canvassed many years previously by H. J. Eysenck, the British experimental psychologist, whose arguments were contested directly by e.g. Cheshire (1964; 1975, pp.1-5 & 135-159; 1979; 1980) and indirectly by Thomä and Kächele (1975). These three respondents pointed to the well-known fact that there are many rigorous and empirically-based disciplines which do not operate on hypothetico-deductive lines, and to the obvious relevance of the methodology of 'hermeneutic' inquiries. It was also argued, following the philosopher of science Rom Harre`, that a 'model-building' paradigm (as implicitly embraced by much psychoanalytic theorising) is just as typical of the natural sciences as is experimentalism (Cheshire 1975, pp. 91-134).

To give up Grünbaum's and Freud's purity myth would bring the psychoanalytic method invented by Freud to its full-fledged form. Insofar as the contemporary crisis differs from all the previous ones it depends on the recognition of the intersubjective, relational nature of the psychoanalytic method. The treating analyst of course contributes to changes and is up to a point capable of observing them. In many respects, psychoanalysis is a science based on clinical observation, but for all kinds of practical reasons the analyst as participant observer would be overburdened by having to combine his therapeutic task with being at the same time of being the researcher. Therapy research in psychoanalysis is a most complex endeavor far beyond the capacity of the treating clinician working in isolation (Bowlby 1979)

. Only a team can do the job implied by Freud's "inseparable bond" thesis, namely that of testing the validity of causal connections observed in the analytic situation. The psychoanalytic literature abounds in vignettes about new discoveries which often lack a convincing description. The "contemporary countertransference subjectivism" seems to solve all practical and scientific problems: If the emotions of the analyst indeed mirrored the unconscious of the patient correctly, if the "third ear or eye" heard or saw the unconscious voices and scenes (as Goethe imagined the "Urphaenomene") then without further ado psychoanalysts would be in a unique godlike position. Although we enjoy similar fantasies, we don't think they offer solutions.

Whatever the role of the countertransference may be in the recognition of unconscious conflicts, the assumed connection between them has to be made evident. The contemporary post-Kleinian and widespread equation of the countertransference with the unconscious fantasies of the patient would be a wonderful solution of all epistemological problems in psychoanalysis. Bott Spillius reports (1988, p.10) that Melanie Klein gave a candidate in supervision, who ascribed his confusions to the patient's projection, the following warning:

”No, dear, *you* are confused” (our italics). There is more to this than an amusing anecdote! Obviously Melanie Klein was against the equation of processes of projective identification with the countertransference.

Nowadays this equation lures analysts in and outside of the Kleinian school into the self-deception that the countertransference has replaced dreams as the new via regia to the unconscious. Far beyond the Kleinian School the fitting countertransference is taken as the adequate instrument for treating very ill patients. This unsubstantiated assertion is used to require a very deep and long training analysis. For instance in a panel on reassessment of psychoanalytic education, controversies and changes, Amati-Mehler stated clearly: “An adequate training analysis…should explore the candidate’s psychotic levels, so as to develop the capacity of candidates to work clinically with the countertransferences that are central to clinical work with very ill patients. Such exploration might not be necessary in a non-training analysis.” (Zimmer (reporter) 2003, pp. 148). Indeed, subjective countertransference is, in Gabbard’s (1995) opinion, our common ground and, in our evaluation, the main reason for the extreme pluralism and the incomparable crisis of contemporary psychoanalysis. From our point of view, this development is a misunderstanding of Paula Heimann’s seminal conception of the intersubjective nature of the countertransference. The ”creation” (Heimann, 1950) of the patient turns into the ”third ear and eye” equipped with the unique quality of having a direct and ”true” access to the patient’s unconscious. This gives analysts a powerful position, especially as the diagnostic quality of the countertransference is made dependent on a proper post-Kleinian training analysis. Freud’s (1912e, p. 116) ”telephone-receiver metaphor” was the forerunner of Reik’s ”third ear” and the post-Kleinian conceptualisation of the countertransference. Since we do not believe in the magical quality of our countertransference we remain modest with regard to the reliability of any diagnostic considerations about unconscious processes. To

bring symptomatic changes into correlation with intersubjective processes and eventually with unconscious schemata as their determining conditions is a difficult undertaking. In other words: micro-analytic descriptions of intersubjective processes have to be related to whatever unconscious clichés generate typical patterns of symptomatic conflict-resolution. We will demonstrate the relationship between hypothesised unconscious processes and detailed interpretations in the session reports of Amalia.

1.3 Limitations and Possibilities of the ”Inseparable Bond” Thesis (“Junktim”)

The following two questions have stayed with us for a long time: 1). Who is capable of solving the clinical problems connected with the thesis of the inseparable bond “between cure and research”; and 2). What ways are appropriate to study processes of change?

Strachey translated the German word Junktim, which is derived from the Latin jugum = ‘yoke’ as ‘inseparable bond’. It seems that German speaking analysts are especially fond of the junktim-idea, of the bond between cure and research, without any effort. To comprehend the consequences of Freud’s thesis for analytic therapies we quote at first the original and then Strachey’s translation. “ In der Psychoanalyse bestand von Anfang an ein *Junktim zwischen Heilen und Forschen*, die Erkenntnis brachte den Erfolg, man konnte nicht behandeln, ohne etwas Neues zu erfahren, man gewann keine Aufklärung, ohne ihre wohltätige Wirkung zu erleben. Unser analytisches Verfahren ist das einzige, bei dem dies kostbare Zusammentreffen gewahrt bleibt. Nur wenn wir analytische Seelsorge treiben, vertiefen wir unsere eben aufdämmernde *Einsicht* in das menschliche Seelenleben. Diese Aussicht auf wissenschaftlichen Gewinn war der vornehmste, erfeulichste Zug der analytischen Arbeit (Freud 1927 a, S. 293 f.; our emphasis). Strachey’s translation goes as follows: “In psychoanalysis there has existed from the very first an *inseparable bond between cure and*

research. Knowledge brought therapeutic success. It was impossible to treat a patient without learning something new; it was impossible to gain fresh insight without perceiving its beneficent results. Our analytic procedure is the only one in which this precious conjunction is assured. It is only by carrying on our analytic *pastoral work* that we can deepen our dawning *comprehension* of the human mind. This prospect of scientific gain has been the proudest and happiest feature of analytic work." (Freud 1927a: 255, our emphasis[7]). Leaving aside the difference between true discoveries and the subjective learning process of an analyst, we would like to underscore the following: Freud made insight and scientific knowledge dependent on therapeutic efficacy by emphasizing that knowledge is connected with therapeutic success and insight is perceived as therapeutically beneficent. In brief: the Junktim must be verified by demonstrations of change-processes, starting from symptomatic changes to arrive hopefully at structural change processes.

The scientific ramifications of the Junktim are usually overlooked. Very many psychoanalysts seem to take it for granted that every therapy is a scientific enterprise (Etchegoyen 1992). Only a minority is skeptical or opposes the idea (Meyer 1998). Shakow (1960) referred to the 'inseparable bond' thesis as a naive misunderstanding of the research process. The treating analyst's personal theories, his "truth" and the effects of its application ("efficacy") must be studied by independent judges (or methods). We agree with Bott Spillius that "clinical analysis is intersubjective" and we subscribe to her basic assumption "that truth exists independently of the thinker and is to be discovered, not constructed" (Bott

[7] Earlier Freud (1912 e) spoke of the famous aspect of the analytic work in which research and treatment coincide but he emphasized that from a certain point onward they antagonize each other. He continued: "It is not a good thing to work on a case scientifically, while treatment is still proceeding – to piece together its structure, to try to tell its further progress and to get a picture of it from time to time as scientific interest would demand." (1912 e p.114) Apparently he had the reconstruction of the etiological reconstruction of a case in mind. From the point of view of scientifically acceptable writing treatment-reports Freud's point of view can be used to postpone the study of change processes ad infinitum.

Spillius 2004 p. 1061). Her quotation of Segal's statement, however, is intriguing: "Psychoanalysis is unique in considering that the search for truth is in itself therapeutic." We doubt, however, that every psychoanalytic search for truth is in itself therapeutic.

For Stoller, the claim that the psychoanalytic method is scientific remains open to question as long as it lacks one essential element found in all other recognized scientific disciplines: "This does not mean that analysts cannot make discoveries, for scientific method is only one way to do that. But it does mean that the process of confirmation in analysis is ramshackle... I worry that we cannot be taken seriously if we do not reveal ourselves more clearly" (Stoller 1979, p. XVI). From the context it seems clear to us that Stoler does not refer to personal revelations but to publicly available recordings of analytic sessions. It is a truism, of course, that the verbatim transcript of a session" is not a record of what happened but only of what was recorded" (Colby and Stoller 1988, p. 42). With the introduction of discourse analysis also into the psychoanalytic arena this kind of argument looses its relevance. After all non-verbal aspects of the communication permeate into the verbal exchanges.

Our interpretation of the Junktim stresses the responsibility of the treating analyst. Clinical research originates in the analytic situation; everything depends on the participation of the analyst. To this extent there is some truth in the 'inseparable bond' thesis, especially if the context of the phrase is taken seriously. As already quoted, the Junktim is only fulfilled if its "beneficent effect" (in German: "wohltätige Wirkung") is proven. Our emphasis that treatment reports have to be centered on processes of change is once more justified. As those processes refer to manifest experiences and behavior and their assumed unconscious roots (Freud's template or schema), it is essential to discuss their relationship to the intersubjective processes in the psychoanalytic situation. Only parts of the patient's experience can be expressed in a "language of observation";

but to deny such a language to psychoanalysis, as Ricoeur (1969 p.366 ff.) did, is from our point of view unjustified.

1.4 Unconscious Schemata as Causal Dispositions

In any clinical research, psychoanalytic and otherwise, the crucial point is that the elimination of an underlying condition which is assumed to be the cause of certain symptoms must change them and eventually bring about their dissolution.

The German philosopher of science, Stegmüller (1969), clearly states: ”If we deal with the elimination of certain phenomena or events which occur only if a defined necessary condition is present, we tend to declare this special necessary condition as the cause of the phenomenon" (p. 435, our translation). Such dispositional explanations are weak and ultimately lead to further causal questions about how a certain unconsciously determined schema developed in the life history going back to early childhood.

Freud’s conception follows the ideal of a causally based therapy. The famous thesis of an ”inseparable bond” (Junktim) uniting treatment and research fits Grünbaum’s requirements as well as the expectations for change of the patient – an amazing agreement – *if* it can be demonstrated for more than one person. The psychoanalytic method becomes epistemologically valid by discovering causal connections. It becomes therapeutically effective by demonstrating that changing the causative conditions (the unconscious disposition) brings about symptomatic relief and possibly structural change. In the German version of our methodological paper (Thomae and Kaechele 1973, Engl. 1975) we spoke of a possible dissolution of a causal connection by psychoanalytic interpretations. This loose formulation was rightly criticized by Grünbaum. Of course, we never had in mind that causality as such was dissolved. Therefore we gratefully accepted Grünbaum’s (1988, p.33) clarification. By

quoting from our textbook he even endorsed our position: ”In the wake of the resolution resulting from the interpretive work, the conditions maintaining the repression (and thus the symptoms) are changed. Eventually the specific unconscious causes of the repression may become ineffective. This change may resolve the processes determined by the causal nexus but not the nexus itself, as emphasized by Grünbaum (1984), the resolution actually confirms the suspected role of the nexus” (Thomae and Kaechele 1992, p.27). Of course it must become evident that the dissolution has been brought about by psychoanalytic means and not by chance or by non-specific suggestions. In his later work Grünbaum (1993) took up the question of dissolution again, this time in a comprehensive sense against Habermas’ hermeneutic turn. In our evaluation the most important point is the following one. If the conditions maintaining the repression are changed by psychoanalytic means, then we have an intra-clinical proof about the role of repression and other hypothetical defense mechanisms in causing neurotic symptoms[8].

We are now on empirical grounds and have to face once more the problem of suggestion. Up to a point Grünbaum’s ‘contamination’ arguments against psychoanalytic observations and interventions are correct; however, he draws the wrong inferences. Our conclusion is different: We feel that it is possible to distinguish a variety of suggestions. For example, an exact interpretation that tallies with what is real in the patient could be looked upon as a special form of

[8] We are well aware that dispositional explanations referring to an unconscious schema raise further questions about causal factors. Therefore here-and-now interpretations may tally with what is real in the patient without clarifying the etiology. Still they fulfill Grünbaums request on intra-clinical experimentation as demonstrated by the systematic work on transference and its interpretation. Eagle and Wakefield (2004), strong supporters of Grünbaum´s position, even admit that a few psychoanalytic researchers (e.g.Crits-Christoph, Cooper,& Luborsky, 1988; Silberschatz, Fretter, Curtis, 1986) have attempted to address this question empirically by defining accuracy of interpretations in terms of their agreement with independent assessments of the patient´s dynamic; „....accuracy of interpretation has been shown to have a modest but statistically significant relation to therapeutic outcome“ (p. 350).

potent suggestion. Both Freud's and Grünbaum's attempts at purification destroy therapy as well as appropriate research in psychoanalysis. The difference between the founder of psychoanalysis and one of his sharpest contemporary critics is that Freud believed that the causal nature of psychoanalytic assumptions can be proven by an analyst being an 'objective', 'neutral' observer, whereas Grünbaum rejected Freud's tally-argument which refers to the following quotation: "After all, his conflicts will only be successfully solved and his resistances overcome if the anticipatory ideas he is given **tally** with what is real in him." (Freud 1917, p. 452). Grünbaum called the 'tally-argument' Freud's master proposition. He declared it untenable mainly for two reasons: improvements or even cures can be effected by rival modalities and also by extra-clinical life events and by the analyst's suggestion leading to contamination. In the context of the Tally-argument and at other places Freud had discussed the problem of suggestion and had distinguished various forms. Grünbaum does not even discuss the possibility to differentiate between various forms of suggestion, and he underestimates the patient's critical attitudes. Both Grünbaum's refutation of the Tally-argument and the Necessary-Condition-Thesis (NCT) collapse: It is empirically possible, and part and parcel of the therapeutic encounter, to discriminate between specific interventions and all kinds of suggestive maneuvers, which for Grünbaum epitomize the scientifically defective foundations of psychoanalysis. His critique of the psychoanalytic method is based on a classical physicist's misapprehension of the human sciences, which are, indeed, impure. It is the task of the analyst to differentiate between various suggestions in order to support the patient's capacities to overcome inner conflicts.

Grünbaum's critique became a source for analysts and philosophers to think about epistemological questions. Fonagy (2003 p. 19) made it quite clear that "most clinical laws are only probabilistic…and therefore they only allow

inductive, statistical explanations rather than deductive nomological ones. Every single case is therefore potentially different, which in turn illustrates the necessity of case-studies but also exemplifies the well-known problems of generalization".[9] Very similar points of view were expressed by Benjamin Rubinstein many years ago. It is an ominous sign that his work on the causal theory of change is either forgotten (Strenger 1997 p. 1046). – or even worse – has become obsolete in the current hermeneutic climate. We are on Rubinstein's side and believe that, in spite of the so called hermeneutic turn (Edelson 1985), all analysts think causally. Extreme subjectivism and constructivism can only conceal our dependence on causal thinking and the need for objectivity, even if we fail to comprehend the whole of intersubjective communication. Our emphasis on the relational, intersubjective character of the analytic method is compatible with attempts to objectify change-processes. As we are only amateurs in epistemological questions, we would appeal to the case made by Cavell (1998 a and b; 2002). From a recent exchange of opinions between Cavell (2002) and Friedman (2002) we quote: "…scientists and philosophers have not at all abandoned the ideas of justification and of knowledge; all they have abandoned is the notion of certainty or indubitability, as anything other than a subjective state of human beings. Belief is a subjective state; but knowledge, though a state of subject, is not a nearly subjective state. The feeling of conviction or of

[9] It seems that Fonagy mixes different levels, namely a) the difference between 'probabilistic'/'statistical' generalizations or laws (on the one hand) and 'universal' ones (on the other) with b) that between induction and deduction. A deductive explanation of a particular case would necessarily have been inferred from some law-like (nomological) generalization, insofar as it was 'deductive'; and the empirical generalization itself will have been inferred inductively, at some remove, from a range of empirical observations. When you infer from a law (statistical or otherwise) to a particular case, where the particular case is a member of the logical class to which the law refers, then that is a deduction. The fact that the deduced proposition may be (often is) only probabilistic is irrelevant to the logic, and hence to the rigor, of the inference. Fonagy combines rigor of the process-of-inference with the rigor (security/comprehensiveness/truth-value) of the law-like proposition used as premises of explanatory arguments.

certainty is also a subjective state; but to say that one knows is to make a claim, a claim that what one says one knows is in fact true. Of course we sometimes feel very certain of what we believe. But that sense of certainty is a merely psychological fact about us. 'Certainty,' Wittgenstein wrote, 'is *as it were* a tone of voice in which one declares how things are but one does not infer from the tone of voice that one is justified'(6e)." (Cavell 2002, p. 320) By completing the hermeneutic turn, which is simultaneously a move towards extreme subjectivity, contemporary psychoanalysis avoids fundamental issues, which belong to Freud's legacy. He could only inadequately or even not at all validate many of his discoveries. The famous so-called Achensee-Question on suggestion by Fliess (cf. Meehl 1983) worried him deeply just about 100 years ago. Freud's explanations of suggestion (1912b: 104) were unsatisfactory (Thomä 1977). Today we are better able to solve this problem and can refute the condemnation of clinical research by Grünbaum (1984, 1993) with good reasons. There is no uncontaminated data within the humanities.

To sum up: Since only probabilistic laws are available in our field single-case studies are maximally suitable to focus on the uniqueness of each human being in psychoanalytic treatment. Inasmuch as conscious and unconscious reasons can be taken as (motivating) causes or intentions, psychoanalytic explanations are philosophically sound. "Hermeneutic" understanding and "causal" explanation do not oppose but supplement each other. Freud's discoveries of unconscious reasons in human action created a new method of understanding by explanation. No wonder that the philosopher von Wright (1994, p. 177f.), among others, finally arrived at the recognition of a type of explanation which he called "explanatory understanding". The apparently naive conviction of psychoanalysts that the historical dichotomy of "Verstehen" and "Erklären" belong to the past, is well founded. The psychoanalytic method helps to deepen the understanding of human experiences by probabilistic explanations.

Psychoanalysts move back and forth between idiographic and nomothetic approaches. It is not possible in principle to do more than to approximate those ideals. To express it by a paradox: the perfect type is the unique single case!

Given that the ultimate aim of psychoanalytic therapy is structural change – i.e. a change in the unconscious conditions – it is essential to make tentative diagnostic assumptions about the unconscious conditions of the patient's experiences and behavior. Micro-analytic descriptions of the therapeutic process have to refer to these unconscious schemata. The hypothetical character of such correlations reaches a high degree of probability if changes brought about through the influence of the analyst are made evident beyond any reasonable doubt. It is most regrettable that in many clinical papers the evidence for such unconscious changes is very often missing. Boesky (2002) recently presented a piece of research entitled "Why Don't Our Institutes Teach the Methodology of Clinical Psychoanalytic Evidence?" At an interval of 10 years (1990 and 2000) he conducted a survey of recognized American psychoanalytic institutes in order to discover whether the curriculum includes courses on the presentation of clinical evidence. In nearly all institutes candidates are not trained to pay attention to evidence criteria in their case reports. So it is no wonder that throughout the psychoanalytical world - whether in vignettes, case histories, membership papers or in clinical discussions - criteria of evidence, implied in Freud's "inseparable bond thesis" are notoriously neglected. The disappearance of symptoms alone does not suffice. Explanations on psychodynamic considerations have to be made with reference to the micro-analytic descriptions of the intersubjective process.

1.5 The Ulm Process Model

In order to fulfil this requirement we have conceptualized the analytic process as a continuous focal therapy with changing psychodynamic topics and

their working through. A serviceable process model must combine flexibility in approaching the individual patient with regularity structured around the therapeutic tasks:

1. Since the patient's free associations by themselves do not lead to the discovery of the unconscious portions of conflicts the psychoanalyst has to make a selection according to his tactical (immediate) and strategic (long-term) goals.
2. Psychoanalytic theories serve to generate hypotheses, which must constantly be tested by trial and error.
3. The utility of therapeutic instruments can be judged by whether the desired change is achieved: if the change fails to occur it is time to evaluate the quality of the therapeutic relationship.
4. Myths of uniformity in psychoanalytic therapies lead to self-deceptions.

These four points of view have resulted from our reviewing the literature on the focus concept. It is essential to take very seriously, that a focus is used as a steering hypothesis and not as a rigid prescription. It is our conviction, that all analyst's unknowingly and intuitively direct their interpretations toward unconscious dispositions, therefore the idea of an aimless non-tendentious analysis is a self-deception. In brief: the idea of "just analyzing" is a self-deception. This fact has only recently been acknowledged by Sandler and Dreher (1996). Patients begin a treatment with conscious and unconscious aims. Analysts also have aims even when they practice a mystical emptying of the mind (Bion's recommendation 1967, 1988).

Against aimless "just analyzing," Sandler and Dreher emphasize: "....those who believe that the aim of the psychoanalytic method be nothing more than to analyze do deceive themselves... all analysts are influenced during the session knowingly or unknowingly by therapeutic aims" (Sandler and Dreher, 1996, p.1). As evidence is missing that "just analyzing" is the optimal way to

achieve the best possible outcomes we cannot but join Sandler & Drehers reproach. Analysts influence their patients even in the "evenly-hovering attention". This 'rule' by implication is directed against premature closure of judgment. Bion's postulate of "no memory and desire" conveys the same attitude.

As becomes obvious from a panel on the "goals of psychoanalysis" that Bartlett (2002) reported on, the Kleinian school seems to be the only one that still sticks to the idea of non-directionality, paying only lip-service to Sandler's and Dreher's critique. Bott Spillius, for example, emphasizes that the ideal of a "strict and pure psychoanalysis" that is implied in the slogan of "just analyzing", should be maintained. To get closer to Bion's ideal of "no memory and no desire" Bott Spillius recommends becoming aware of one's aims in order to be able to effectively ignore them. Most Kleinian analysts – with the exception of J. Steiner – are said to be opposed to the conceptual discussions on goals. By rejecting any specific aims they assume the possibility of reaching any possible goal. The leading idea is thus that aims come about all by themselves, i.e. by strict analysis in the Kleinian "Here and Now".

We however are of the strong conviction that through our interventions, whether based on intuition or reason, we are knowingly or unknowingly causal agents with intentions. Upon reflection it should be possible for us to recollect the intentional background of our interpretations.

In the reconstruction of case histories one can dispense with the recounting of aims. For treatment reports, however, it is decisive which aims are followed by the patient and by the analyst and what interactional conditions facilitate change rather than standing in its way.

Part II: The Case of Amalia[10]

2.1. Introductory Comments to the Audio-recording of Analytic Treatments

It is remarkable how many problems an analyst has to cope with when he gives a colleague the data from his work even more so if the dialogue is audio-taped and transcribed. Colleagues confirm more or less bluntly what one's self evaluation actually cannot overlook, namely that there can be a significant discrepancy between one's professional ideal and reality. My very idiosyncratic style of interpreting[11] makes some editing of the original text necessary. My involvement has the peculiar consequence that I am often seeking the most appropriate words and start sentences anew.

Tape recording is a relative neutral procedure with respect to the contents of recording; it will not miss spoken words as long they are loud enough to be recorded. Transcripts often seem paltry in comparison to the recollections that the analyst has of the session. When reading a transcript or listening to a tape one has to revitalize the clinical situation by identifying with both, the patient or the analyst. It is the rich cognitive and emotional context that adds vitality to the sentences expressed by the patient and the analyst. It certainly will be a matter of training to fill in the gaps with the aid of one's imagination and one's own experience (like musicians able to read scores). In the traditional presentation of case material, which in general contains much less of the original data, this enrichment is provided by the author's narrative comments. Even the use of generalizations, i.e., of the abstract concepts that are regularly employed in clinical narratives, probably contributes to making the reader feel at home. The

[10] In the second part we change the style of our text. The treating analyst (H.T.) speaks now in the first person.

[11] Among the many scholars who worked on those transcripts Jimenez (2004) description of my personal style is to the point.

concepts that are used are filled – automatically, as it were – with the views that the reader associates with them. If a report refers to trauma or orality, we all attribute it a meaning on the basis of our own understanding of these and other concepts that is in itself suited to lead us into approving or skeeptical dialogue with the author.

For Sandler and Sandler (1984, p. 396) the ”major task for future researchers” is “to discover why it is that the transcribed material of other analysts’ sessions so often makes one feel that they are very bad analysts indeed.” They qualify this by adding that this reaction ”is far too frequent to reflect reality” and ask “can so many analysts really be so bad?” It is remarkable that the Sandlers made this comment in a special issue of the “Psychoanalytic Inquiry”, devoted to Merton Gill’s innovative contribution to psychoanalytic technique. My somewhat ironic rejoinder to this observation is the following: Both of the Sandlers would belong to those bad analysts, if they had presented audio-taped dialogues without giving their thoughts and feelings to put the flesh on the verbal skeleton. In other words, oral reports convey some of the emotional climate of the analytic situation to the audience; but without additional editing, and an augmentation of the transcribed material by the treating analyst, the pure record alone is, indeed, paltry.

In retrospect we can say that the introduction of tape-recordings into psychoanalytic treatment was linked with the beginning of a critical reappraisal of therapeutic processes (Gill et al. 1968; Rosenkötter & Thomä 1970). This simple technical tool was, and still is the object of a subsiding controversy among psychoanalysts (Wallerstein 2003)[12].

[12] As head of the Department of Psychotherapy at the Ulm University, and director of the newly founded Psychoanalytical Institute under one roof with the University department, I started with tape-recording of psychoanalytic treatments in 1968, as did Dahl in 1968 at New York University with supervision by Jacob Arlow. I exposed myself to the critique of my co-workers and young candidates and learned a great deal from their evaluation. I mention with some pride that already in 1968, at a

I believe that the introduction of research into the psychoanalytic situation is of great benefit to the patient. It enables the analyst to learn more than from any other kind of supervision. Clinical discussions based on audio-taped sessions come very close to the heart of the matter, if the analyst gives background information. A transcript creates the impression of being one-dimensional: the analyst's interpretation and the patient's answers do not automatically reflect latent structures, although typical interpretations disclose which school the analyst belongs to. Some 20 years after our empirical investigations of audio-recordings of the psychoanalytic dialogue (Kächele et al 1988) we would like to encourage our colleagues to use that instrument in order to improve their therapeutic capacities.

2.2. The Need for Annotation

In order to enrich the understanding of the following sessions I shall give each intervention some background information. These "considerations" are subsequently added to the exchange between patient's and analyst´s responses. It is obvious that in arriving at my interventions I was led not only by the ideas described in the text. Whatever way interpretations have been created, any interpretation actually made must be aligned along 'cognitive' criteria, as demanded by Arlow (1979). My comments refer to the 'cognitively' and 'rationally' determined "end-products" (the interventions themselves) and neglect the intuitive, unconscious components in their genesis. Therefore I rarely refer to my countertransference. I am an eclectic psychoanalyst and an intersubjectivist (cf. Pulver 1993; Thomä 2004). With regard to the countertransference I am as

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meeting of the German Psychoanalytic Association in Ulm, I presented in the presence of Paula Heimann a psychoanalytic investigation based on tape-recorded sessions. Twelve completely audio-taped analyses and analytic therapies of mine are now stored in the Ulm Text Bank as part of the Section for Informatics in psychotherapy directed by Prof. Dr. E. Mergenthaler and Prof. Dr. H. Kächele

old-fashioned as Melanie Klein (cf. the anecdote mentioned above). I do not believe that countertransference is brought about by projective identification. There may be typical interactional patterns of transference and countertransference, but I think it is the responsibility of the analyst to make the best for the patient of his emotional reactions.

The source of each of my analytic thoughts remains an open question. If we assume that the analyst's perceptive apparatus is steered by his theoretical knowledge, which may have become preconscious, then it is very difficult to trace the genesis of interpretations back to their starting points. For example, theoretical knowledge about displacement also facilitates preconscious perception; it pervades the analyst's intuition and blends with his emotional reactions. These ”considerations” are my second thoughts. For all clinical and naturally controversial discussions, I recommend taking the background information as the starting point of our exchange. In other words, I hope that my considerations are coherent enough to be critically discussed. Such a coherence is important because it supports my hypotheses about the patterns in the patient.

2.3. Amalia’s Symptomatology and Its History

Amalia X (born 1939) was in psychoanalytic treatment (517 sessions) during the early seventies with good results. Some years later she returned to her former therapist for a short period of analytic therapy because of problems with her lover, many years her junior. Twenty five years later she consulted a colleague of mine as her final separation from this partner had caused unbearable difficulties and she again asked for circumscribed help.

Amalia X came to psychoanalysis because the severe restrictions she felt on her self-esteem had made her vulnerable to depression in the last few years. Her entire life history since puberty and her social role as a woman had suffered from the severe strain resulting from her hirsutism. Although it had been possible

for her to hide her stigma – the virile growth of hair all over her body – from others, the cosmetic aids she used had not raised her self-esteem or eliminated her extreme social insecurity. Her feeling of being stigmatized and her neurotic symptoms, which had already been manifest before puberty, strengthened each other in a vicious circle; scruples from a compulsion neurosis and various symptoms of anxiety neurosis impeded her personal relationships and, most importantly, kept the patient from forming closer heterosexual friendships.

This woman, who was hard-working in her career, cultivated, single and quite feminine despite her stigma, impressed me positively. I was relatively sure and confident that it would be possible to change the significance she attributed to her stigma. In general terms, I proceeded from the position that our body is not our only destiny and that the attitude which significant others and we ourselves have to our bodies can also be decisive. Freud's (1912d, p. 189) paraphrase of Napoleon's expression to the effect that our anatomy is our destiny must be modified as a consequence of psychoanalytic insights into the psychogenesis of sexual identity. Sexual role and core identity originate under the influence of psychosocial factors on the basis of one's somatic sex (see Lichtenstein 1961; Stoller 1968, 1975; Kubie 1974).

My previous experience warranted the following initial assumptions. A virile stigma strengthens penis-envy and reactivates oedipal conflicts. If the patient's wish to be a man had materialized, her hermaphroditic body image would have become free of conflict. The question "Am I a man or a woman?" would then have been answered; her insecurity regarding her identity, which was continuously reinforced by her stigma, would have been eliminated; and self-image and physical reality would then have been in agreement. It was impossible for her to maintain her unconscious fantasy that she was a man, however, in view of her female genital. A virile stigma does not make a man of a woman. Regressive solutions, such as reaching an inner security despite her masculine

stigma by identifying herself with her mother, revitalized old mother-daughter conflicts and led to a variety of defensive processes. All of her affective and cognitive processes were marked by ambivalence, so that she had difficulty, for example, deciding between different colors when shopping because she linked them with the qualities of masculine or feminine.

2.4. Some Remarks about the Psychodynamic Background of the Two Sessions

When structuring the psychoanalytic situation and dealing with problems of the described type, the analyst must pay extra attention to not letting the asymmetry of the relationship excessively strengthen the patient's feeling of being different.

This is important because the idea of being different - that is, the question of similarity and difference, of identity and non-identity - forms the general framework within which unconscious problems appear. In this case the analyst and patient succeeded relatively quickly in establishing a good working relationship, creating the preconditions for recognizing during the development of the transference the internalization of earlier forms of interaction with primary reference persons – such as parents and teachers. The correction that was achieved can be seen in the changes in her self-esteem, in her increased security, and in the disappearance of her symptoms (see Neudert et al. 1987).

In retrospect, almost thirty years later, I have the following after-thoughts about my personal understanding of the psychoanalytic method at the time. I think I was quite successful in establishing a helping alliance which made it possible to make transference interpretations with regard to processes of ”displacement and condensation”. The head is the symbol for understanding and communication and simultaneously a symbolic expression of the penis and the phallus in the sense of Lacan.

The two excerpts of sessions given below are linked by the fact that each is concerned with enabling the patient to make new identifications as a result of the analysis of transference. The analyst's "head" became the surrogate of old, unconscious "objects," and its contents the representative of new opportunities. The representation of the "object," which is simultaneously a self-representation, made it possible to establish a distance, because the analyst made his head available and kept it too. Thus he became a model for both closeness and distance. This example clearly demonstrates the therapeutic effect that insight into unconscious connections mediated by the analyst's interpretations can have. I think that my fantasies and thoughts tallied with the psychic reality of the patient.

We have selected this material because in our opinion it is suited to provide several lines of support to our argument. Although the head acquired sexual importance as a result of the process of unconscious displacement, this displacement did not alter anything regarding the primacy of emotional and intellectual communication, between the patient and the analyst, about what she was looking for as if it were hidden inside my head. The search for knowledge was directed at sexuality. This secret and well-guarded (repressed) treasure was assumed to be in the head (as the object of transference) because of the unconscious displacement. The revelation of "displacement" brought something to light that was "new" to the patient.

The patient suffered from severe feelings of guilt, which were actualized in her relationship to me. The Biblical law of an eye for an eye and a tooth for a tooth was reinforced in her experience because of her sexual desires. Her life-historical role-model for the contents of her transference was a fantasized incestuous relationship to her brother. The increase in inner tension led the patient on the one hand to reconsider the idea of dedicating her life to the church as a missionary and on the other to contemplate committing suicide. (As a young

girl she had wanted to become a nun and nurse, but gave up this idea after a trial period because the pious confinement became too much for her. Leaving also helped her to establish some distance from the strict biblical commandments.) Now she wielded her "old" Bible against me, "in a fight to the finish." This fight took place at different levels, and the patient invented a series of similes for them. She had the feeling that the analyst's dogma, the "Freud Bible," could not be reconciled with her Christian Bible. Both bibles, however, contained a prohibition of sexual relations with the analyst.

The patient struggled for her independence and needs, which she defended against both of these bibles. She developed an intense defense against my interpretations, and she had the feeling that I knew in advance exactly "what's going to happen." She felt humiliated because her detors and distractions had been detected. She had the intense desire to mean something to me and to live in me; she thought about giving me an old, lovely, and wonderful clock that would strike every hour for me (and for her).

In this phase of the treatment one topic took on special significance and intensity: this was her interest in my head. What had she learned from measuring my head? In a similar situation Amalia X had once said that for a long time she had thought that I was looking in her – of what was already there – in books, in my thoughts, in my head. She wished that something completely new would come out. She herself looked for interpretations and made an effort to understand my ideas.

2.5. Transcripts of Parts of Sessions 152 and 153

At the beginning of the session Amalia reported an uncanny dream in which she was stabbed in the back by a man, thus she introduced the general topic of a fight between a man and herself with all the different levels and meanings of

fights between the sexes. The focus of the session was a rather broad one. Amalia changed her role as a victim and became a perpetrator. In the next session she remembered that she had completely forgotten that she had looked on me as a young man with a head symbolizing a phallus. Her momentary forgetting is a beautiful example of Luborsky's (1967; 2001) attention to small parapraxes as symptoms.

At first Amalia fell into a role of masochistic subordination and I commented by saying:

A: You presume that I'm sitting behind you and saying "wrong, wrong."

Consideration. This transference interpretation was based on the following assumption. The patient attributed to me a "superego function." This interpretation took the burden off her and gave her the courage to rebel (the patient had recognized long before that I was different and would not criticize her, but she was not sure and could not believe it because she still had considerable unconscious aggressions against old objects). I assumed that she had much more intense transference feelings and that both the patient and I could tolerate an increase in tension. I repeated her concern that I could not bear it, and finally formulated the following statement: "Thus it's a kind of a fight to the finish, with a knife" (not specifying who has the knife). I made this allusion to phallic symbolism to stimulate her unconscious desires. It was an overdose! The patient reacted by withdrawing. Assumption: self-punishment.

P: Sometimes I have the feeling that I would like to rush at you, grab your neck, and hold you tight. Then I think, "He can't take it and will suddenly fall over dead.

A: That I can't take it.

The patient varied this topic, expressing her overall concern about asking too much of me and of my not being able to tolerate the struggle.

A: It's a kind of a fight to the finish, with a knife. (This interpretation alludes to Amalia‘s dream about being stabbed, reported at the beginning of the session. As I had not mentioned this dream in my oral presentation, listener wondered where the idea of the knife came from.)

P: Probably.

She then reflected that she had always, throughout the years, given up prematurely, before the struggle had really begun, and withdrawn.

P: And I don't doubt any more that it was right for me to withdraw. After such a long time I have the urge to give up again.

A: Withdrawal and self-sacrifice in the service of the mission instead of struggling to the end.

P: Exactly, nerve-racking.

Consideration. She was very anxious about losing her object.

A: Then I would have the guarantee of being preserved. Then you would have broken off my test prematurely.

We continued on the topic of what I can take and whether I let myself be carried along by her "delusion." The patient had previously made comparisons to a tree, asking whether she could take anything from it, and what it would be. I returned to this image and raised the question of what she wanted to take along by breaking off branches.

Consideration. Tree of knowledge – aggression.

P: It's your neck, it's your head. I'm often preoccupied with your head.

A: Does it stay on? You're often preoccupied with my head?

P: Yes, yes, incredibly often. From the beginning I've measured it in every direction.

A: Hum, it is . .

P: It's peculiar, from the back to the front and from the bottom. I believe I'm practicing a real cult with your head. This is just too funny. With other people I'm more likely to see what they have on, just instinctively, without having to study them.

Consideration. To create shared things as primary identification. [This topic was discussed for a long period of time, with some pauses and "hums" by the analyst.]

P: It's simply too much for me. I sometimes ask myself afterwards why I didn't see it, it's such a simple connection. I am incredibly interested in your head. Naturally, what's inside too. No, not just to take it along, but to get inside your head, yes above all, to get inside.

Consideration. The partial withdrawal of the object increased her unconscious phallic aggressiveness.

The patient spoke so softly that I did not even understand "get inside" at first, mistaking it for "put inside." The patient corrected me and added a peculiar image, "Yes, it's so hard to say in front of 100 eyes."

P: Get inside, the point is to get inside and to get something out.

Consideration: I saw this getting inside and taking something out in connection with the subject of fighting. It was possible to put the sexual symbolism, resulting from the displacement from the bottom to the top, to therapeutic use by referring to a story that the patient had told in an earlier session. A woman she knew had prevented her boyfriend from having intercourse with her and had masturbated him, which she had described by analogy to head-hunter jargon as "head-shrinking." The unconscious castration-intention dictated by her penis envy created profound sexual anxiety and was paralleled by general and specific defloration anxieties. These anxieties led in turn to frustration, but one which she herself had instinctively caused, as a

neurotic self-perpetuating cycle. The repression of her sexual and erotic desires that now occurred unconsciously strengthened the aggressive components of her wanting to have and possess (penis desire and penis envy).

A: That you want to have the knife in order to be able to force your way in, in order to get more out.

After we exchanged a few more thoughts, I gave an explanation, saying that there was something very concrete behind our concern with the topics of getting inside, head, and the fight to the end with a knife.

A: The woman you mentioned didn't speak of "head shrinkers"[13] for nothing.

P: That's just the reason I broke off this line of thought. [For about ten minutes the patient had switched to a completely different subject.]

After expressing her insight into her resistance to an intensification of transference, she again evaded the topic. She interrupted the intensification, making numerous critical comments.

P: Because at the moment it can be so stupid, so distant. Yes, my wishes and desires are the point, but it's tricky, and I get real mad, and when head and head shrinking are now . . .

She laughed, immediately expressed her regret, and was silent. I attempted to encourage her.

A: You know what's in your head.

P: Right now I'm not at all at home in mine. How do I know what will happen tomorrow. I have to think back. I was just on dogma and your head, and if you want to go down . . .[to a shrunken head]. It's really grotesque.

Consideration. I first mentioned the shrunken heads because I assumed that the patient would be more cooperative if the envious object relationship could be replaced by a pleasurable one.

[13] The derogatory colloquial "headshrinker" (=psychiatrist) has no Germen counterpart and is unknown to Amalia. Her expression "Schrumpfköpfe machen" refers to a custom of Polynesian cannibalistic warriors who dry up the heads of enemies they have killed.

Then the patient came to speak of external things. She described how she saw me and how she saw herself, independent of the head, which then again became the focus of attention in a general sense.

A: By thinking about the head you're attempting to find out what you are and what I am.

P: I sometimes measure your head as if I wanted to bend your brain.

The patient then described the associations she had once had when she had seen my picture printed somewhere.

P: I discovered something completely different at the time. There was an incredible amount of envy of your head. An incredible amount. Now I'm getting somewhere at any rate. Whenever I think of the dagger and of some lovely dream.

Consideration. The patient obviously felt caught. She felt humiliated by her own association, as if she had guessed my assumption as to what the envy might refer to. In this case I would have rushed ahead of her, so to speak.

A: Humiliating, apparently to you, as if I already knew which category to put it in when you express envy, as if I already knew what you are envious of.

P: That came just now because you had referred to the shrunken heads, which I didn't even make. But what fascinated me is this fight to the finish, for the knife, to get to the hard part . . . .Yes, I was afraid that you couldn't take it. My fear that you can't take it is very old. My father could never take anything. You wouldn't believe how bland I think my father is. He couldn't take anything.

Consideration. A surprising turn. The patient's insecurity and her anxiety about taking hold developed "unspecifically" on her father.

A: It's all the more important whether my head is hard. That increases the hardness when you take hold.

P: Yes, you can take hold harder . . .and can - simply - fight better.

The patient then made numerous comments to the effect of how important it was that I did not let myself be capsized, and she returned to her envy. Then she mentioned her university studies again, and how she used to "measure" the heads of the others. Then she introduced a new thought.

P: I want to cut a little hole in your head and put in some of my thoughts.

Consideration. An objectivistic image of "intellectual" exchange as a displacement?

The patient's idea about the two-sided nature of the exchange led me to recognize another aspect of this fight. It was also an expression of how important it was to me that she remains a part of the world (and in contact with me), and digress neither into masochistic self-sacrifice nor into suicide.

P: That came to me recently. Couldn't I exchange a little of your dogma for mine. The thought of such an exchange made it easier for me to say all of this about your head.

A: That you continue coming here so that you can continue filling my head with your thoughts.

Consideration. Fertilization in numerous senses – balance and acknowledgment of reciprocity.

P: Oh yes, and mentioning really productive ideas.

The patient returned to the thoughts and fantasies she had had before the session, about how she had been torn back and forth. Whether she had a future at all, and whether she shouldn't withdraw in some way or other and put an end to it all.

At the beginning I had attempted to relieve her intense feelings of guilt with regard to her destructiveness. I picked up the idea once again that her thoughts about my stability were in proportion to her degree of aggressiveness. The patient could only gain security and further unfold her destructiveness if she found strong, unshakable stability. The topic of dogmatism probably belonged in this context. Although she criticized it - both her own Bible and my presumed belief

in the Freud bible - it also provided her security, and for this reason the dogmatism could not be too rigorous or pronounced.

A: Naturally you wouldn't like a small hole; you would like to put in a lot, not a little. The idea of a small or large hole was your shy attempt to test my head's stability.

My subsequent interpretation was that the patient could also see more through a larger hole and could touch it. She picked up this idea:

P: I would even like to be able to go for a walk in your head.

She elaborated on this idea and emphasized that even earlier, i.e., before that day's session, she had often thought to herself how nice it would be to relax in me, to have a bench in my head. Very peacefully she mentioned that I could say, when looking back on my life when I die, that I had had a lovely, quiet, and peaceful place to work. (My office was opposite a very old cemetery, now used as a park.)

Consideration. Quiet and peacefulness clearly had a regressive quality, namely of completely avoiding the struggle for life.

The patient now viewed her entering the motherhouse as if a door had been wide open and she had turned away from life. She then drew a parallel to the beginning of the session, when the door was open.

P: I really didn't have to drill my way in. Yes, there I could leave the struggle outside, I could also leave you outside, and you could keep your dogmas.

A: Hum.

P: And then I wouldn't fight with you.

A: Yes, but then you and your dogma would not be afraid of mine. In that setting of peace and quiet everything would remain unchanged, but the fact that you interfere in my thoughts and enter my head shows that you do want to change something, that you can and want to change something.

About five minutes into the next session (153), the patient returned to my head and measuring it and to the fact that it had disturbed her that I had started talking about the shrunken heads.

P: I told you so. Why do you simply want to slip down from the head?

She then described how she had hardly arrived at home before she recalled the thoughts she had had when she had said hello but then had completely forgotten during the session.

P: To me, he [the analyst] looks as if he is in his prime, and then I thought about the genitals and the shrunken heads. [But she quickly pushed this thought aside, and it was completely gone.] When you started with the shrunken heads, I thought, "Where has he got that again?"

The next topic was the question of my security and my dogmatism, and it was clear that the patient had taken a comment I had once completely undogmatically made about Freud and Jung (I have forgotten what it was) to be dogmatic. She then thought about living a full life, about the moment when everything stopped for her and she became "ascetic," and about whether everything could be revived. Then she again mentioned fighting and my head.

P: I was really afraid of tearing it off. And today I think that it's so stiff and straight, and I think to myself, "I somehow can't really get into my head. I'm not at home. Then how should I get into yours?"

The patient then began to speak about an aunt who was sometimes so very hard that you might think you were facing a wall. She then continued about how hard and how soft she would like her head to be. Her fantasies revolved, on the one hand, around quiet and security; on the other hand, she was concerned about what might be hidden in her head and the danger of it consuming her.

Consideration. This obviously involved a regressive movement. The patient could not find any quiet and relaxation because her sexual desires were linked with pregenital fantasies, which returned in projected form because they were in

danger of being consumed. These components were given their clearest, and in a certain sense also their ultimate, expression in an Indian story the patient later associated, in which mothers gave pleasure to their little sons by sucking on their penises but bit them off in the process.

The comparisons of the heads and their contents always revolved around the question of whether they went together or not.

P: The question of how you have your thoughts and how I have mine . . .Thoughts stand for many things . . . .

A: How they meet, how they rub off on one another, how far they penetrate, how friendly or unfriendly they are.

P: Yes, exactly.

A: Hum, well.

P: You said that a little too smooth.

The patient thought about all the things that scared her and returned again to the shrunken heads.

P: There I feel too tied to sexuality. The jump was too big.

The topic was continued in the question of her speed and of the consideration I pay to her and her speed.

P: But it is true; naturally it wasn't just your head but your penis too.

Amalia X was now in a position, with phases of increasing and receding anxiety, to distinguish between pleasure from discovering intellectual connections and sexual pleasure. The couch became her mental location of sexual union, and her resting in my head the symbol of pregenital harmony and ultimately the location of shared elements and insight. This aspect became even clearer a little later.

Summary

In the center of the psychodynamic focus of the two sessions is the process of displacement within the patient’s body-image into the transference. The head is

used as a transference object. At the same time the patient uses the analyst's thought processes localized in his head as new experience in order to overcome transference repetitions. Insofar, the two sessions contain changes brought about by the offer of the thoughts and feelings of the analyst as a new object (Loewald 1960, Gabbard and Westen 2003). From a microanalyitc point of view the verbatim protocol contains details, which cannot be covered by the molar abstraction of the session.

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Prof. Dr. med. Helmut Thomä

Funkenburgstr. 14 04105 Leipzig

Tel.: 0341/55038-83 Fax: -84

e-mail: thomaeleipzig@aol.com

Acknowledgment
I am grateful to my English colleague Neil Cheshire (Clinical Psychologist) for his helpful comment on an earlier draft of this paper, which not only made it read better in English, but also improved the content in some places. I take this opportunity to record my appreciation of a working partnership and personal friendship that goes back nearly three decades now. It included joint projects both in my former department at the University of Ulm and also as Rockefeller Foundations Scholars at Belaggio in Italy (Cheshire & Thomä, 1987, 1991).